Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST LLC
PO BOX 890008
HOUSTON TX 77289

Respondent Name

HARTFORD INS CO OF THE MIDWEST

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-12-0667-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HeathTrust performed 5 sessions of individual psychotherapy that was preauthorized by the URS of Gallagher Bassett…Coventry prepared the letter and not the first issue of extent or compensability is noted on said preauthorization letter. As per the code, if there are ANY issues of extent or compensability, they are to be noted on said preauthorization…Initially Gallagher Bassett denied the dates of service based on extent issues…Gallagher Bassett has changed its position on the denial reasons and is now stating that "lack of medical necessity" is the reason for non-payment. If that is the case, then the preauthorization itself establishes medical necessity and that cannot be rescinded."

Amount in Dispute: $737.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier accepts the compensable injuries resulting from the 6/5/09 as; cervical HNP @ C5-6, ACL tear of left knee and lumbar strain only. The carrier disputes any other diagnosis or extent of injury as not related to the accepted compensable injury, and not suffered in the course and scope of employment and not in any other way compensable "

Response Submitted by: Gallagher Bassett 6504 International Parkway Suite Plano TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15, 2010 through November 12, 2010	90806	$737.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. 28 Texas Administrative Code §124.2 relating to Carrier Reporting and Notification Requirements
5. 28 Texas Administrative Code §134.600 sets out the procedures for prospective and concurrent review of health care.
6. This request for medical fee dispute resolution was received by the Division on October 31, 2011.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 6, 2010 July 30, 2011
   - 50- These are non-covered services because this is not deemed a 'medical necessity' by the payer.
   - 219 Based on Extent of Injury

Findings

1. 28 Texas Administrative Code §134.600 (c) states in pertinent part, the carrier is liable for all reasonable and necessary medical costs relating to the health care that was approved prior to providing the health care. Review of documentation submitted finds that the carrier approved 6 Individual Psychotherapy sessions (90806) as medically necessary. The carrier shall not withdraw a preauthorization or concurrent review approval once issued.
2. 28 Texas Administrative Code §133.307 (2)(D) if the carrier has raised a dispute pertaining to liability for the claim, compensability, or extent of injury, in accordance with 28 Texas Administrative Code §124.2 of this title (relating to Carrier Reporting and Notification Requirements), the request for medical fee dispute resolution will be held in abeyance until those disputes have been resolved by a final decision of the commission.
3. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of compensability, extent and/or liability for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved prior to the filing of the request for medical fee dispute resolution.
4. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered..

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 23, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.